

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

January 30, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Essential Health Benefits Bulletin, Center for Consumer Information and Insurance Oversight (CCIIO)

Dear Secretary Sebelius:

Thank you for the opportunity to comment on the Bulletin issued last month regarding the proposed regulatory approach to defining the Essential Health Benefits under Section 1302 of the Affordable Care Act. In it, you indicate that you plan to issue future guidance on essential health benefit implementation in the Medicaid program. It remains unclear how the ACA EHBs might differ from EHBs in Medicaid, the priority program for the population we serve. This letter describes our overall concerns based on the CCIIO Bulletin issued on December 16, 2011, and it is our hope that the concerns expressed here and elsewhere by patient advocates will influence key decisions regarding Medicaid and the final regulatory approach to the essential health benefits provisions of the ACA.

The National HCH Council is a membership organization comprised of HRSA Health Care for the Homeless grantees and other homeless health care providers, individual clinicians and service providers, researchers, consumers, and advocates who are united in the belief that access to affordable, high quality, comprehensive health care can prevent homelessness, as well as ameliorate it. The 12 organizations signing onto this letter endorse the aim of these comments and represent other national advocacy and service groups focused on homelessness and issues related to very low-income individuals, families and children. Our shared agenda is to end homelessness through access to health care, affordable housing, decent incomes and benefit levels, quality education, and sufficient support services that allow for independent living.

The concerns outlined in this letter stem from our long-standing experience with disparities in health related to social determinants like poverty and lack of housing. Individuals experiencing homelessness are three to six times more likely to experience illness and injury, and die an average of 30 years earlier than their housed counterparts. They are more likely to have

complex, co-occurring chronic and acute illnesses, behavioral health problems, and very high utilization of health care services. At the same time, many who are homeless do not have health insurance because they do not qualify for Medicaid under current rules and lack the resources to obtain insurance at the individual level (65% of the 805,064 patients served by HCH grantees in 2010 were uninsured, even though 90% earned <100% of the federal poverty level). The expansion of Medicaid in 2014 to most people earning at or below 138% FPL will be a significant step toward better health and is a fundamental component of *Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness*.¹

While we have been very impressed with the efforts to achieve a national standard for Medicaid enrollment and eligibility, we are concerned about the variability and lack of comprehensiveness likely to come from the state-by-state approach to benefits outlined in the December 16 Bulletin. We would like to see a national standard of care defined, with States encouraged to improve upon this baseline. Not only would this approach be in keeping with the spirit (if not the letter) of the Affordable Care Act to ensure access to health coverage that treats and prevents health conditions, especially among vulnerable populations, but it will protect against the economic incentive within states to whittle down services to minimal levels. The following outline the areas of our concerns more specifically:

- **A national standard is needed:** The current system is characterized by state-by-state determinations on benefits; unfortunately, this method has contributed to disparities in coverage based on geographic location and dominant local political views, and tends to emphasize costs as the decision-driver rather than meeting patients' health needs. Under this proposal, we will continue to have a care system based on where you live, not your health care needs. **Our recommendation:** Use a traditional Medicaid package as a national standard for all plans. The EPSDT package for children is held in high regard for its comprehensiveness. Likewise, the preventive service standards contained in the Public Health Service Act Section 2713 could also serve as a baseline guide. Not only would a comprehensive standard meet the needs of most community members, but it would keep a uniform package of services as patients transition from Medicaid to plans in the Exchange, or move between Medicaid eligibility groups (e.g., as single adults become parents, as people relocate from one area to another, etc.). It would also ensure a basic set of services for Medicaid enrollees if they move from one State to another, a reality especially for homeless persons and others seeking opportunity during these difficult economic times.
- **Defaulting to a small group plan is a concern:** Small group coverage is, by definition, for small groups, usually employees, and not necessarily appropriate for larger, more diverse groups of people. Using these plans as a default for those states that choose not to select a benchmark is particularly troublesome given that they typically cover healthier, higher income populations. Small group plans primarily focus on controlling cost and use conservative standards to determine medical necessity. Given that managed care will be overwhelmingly the model for delivering Medicaid (half of these MCOs are currently for-profit entities), we are particularly concerned that cost, not health, will be the motivator for

¹ U.S. Interagency Council on Homelessness. (June 2010.) *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*. Available at: http://www.usich.gov/opening_doors/

coverage decisions. This is a very concerning precedent for HHS to set. **Our recommendation:** While a national standard is far preferable, should HHS continue to pursue this approach, states should be required to choose and/or create a plan that offers more breadth and depth of services than small group plans.

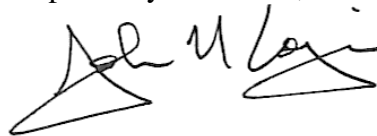
- **Need details on benefits:** The current proposal does not address the clear need to be comprehensive and deep with regard to benefits, but risks the thinnest of coverage, only barely meeting the letter of the ACA, which was kept broad in the belief that HHS would be providing this detail. While a benefit category may be present in a state’s plan, there is no guidance being issued regarding scope, amount and duration of services to be provided. As health care providers who treat patients with intensive needs, there is a vast difference between a limit of ten, 30-minute outpatient mental health visits per year (the mental health benefit under some private plans) and having an adequate array of services to effectively treat individuals with serious mental illness. Another example would include the amount, scope and duration of specialty care services included, and how medical necessity is determined for all types of services. **Our recommendation:** HHS should provide the details behind “essential” in each of the ten categories so that states know how to supplement more intense services for those populations that will need them, such as individuals experiencing homelessness.
- **Supplementing missing categories with other plans does not ensure comprehensiveness:** As the December 16 Bulletin outlines, not all benchmark plans include all ten categories, especially with regard to behavioral health. Unfortunately, HHS’s guidance to “supplement the missing categories using the benefits from any other benchmark option” brings us back to the limitations of private plans generally, the economic incentive for states to choose the thinnest set of benefits possible, and our concern about meeting patients’ needs.
- **Many state mandates could be accommodated with a national standard:** Mandates within states are often a response to narrow insurance coverage policies—often in the individual and/or small group market (e.g., lengths of hospital stays after childbirth or other procedures, hospice care, treatment for Alzheimer’s, cancer-related treatments, etc.). These mandates provide consumer protections and critical care for vulnerable groups and are usually needed to fix service gaps created by the private market models already in practice at the state level; HHS is merely endorsing this approach, with which we have deep concerns. While the Bulletin creates a two-year grace period for states to continue mandates without incurring costs, is it HHS’ intent to use this period to evaluate state mandates across the board, with the intention of issuing stronger, more centralized requirements? We are concerned this otherwise creates an economic incentive for states to eliminate (now or in the near future) many of the mandates that were created specifically to address disparities in coverage created by the same market forces that now will dominate the benefit level decision-making. **Our recommendation:** develop a national standard using common state mandates as a rationale for inclusion.
- **Require states to address special populations in their plans:** Absent a national comprehensive and defined benefit package, HHS should require states to outline how populations with complex, co-occurring health care needs will be accommodated in their

ACA implementation efforts. For homeless populations, these plans should include targeted outreach, case management, supportive/enabling services, medical respite care (for individuals discharged from hospitals), incentives to connect patients to permanent housing, protections against co-pays and other barriers to care for very low-income populations, and a focus on prevention. If individuals experiencing homelessness cannot access comprehensive care that addresses their complex conditions, we will continue to experience high rates of service utilization without positive outcomes, a failure to turn the cost curve, and ongoing disparities in health that prevent independent and stable living.

Overall, we understand the reasons why the Administration would emphasize state flexibility; however, we believe that the current proposal to entrust the health benefits for the 32 million people who gain health insurance coverage through the ACA to the uncertain parameters of a private markets plans (and a small-group plan as a default) will significantly undermine the goals of the Affordable Care Act and not create the changes needed to establish a national standard of health care. Other advocates, we know, are expressing similar concerns.

We appreciate the opportunity to comment on this proposed direction for Essential Health Benefits. As health care providers, we are very concerned about the ability of our clients to access a full spectrum of care that can meet intensive health care needs. Please do not hesitate to contact me to discuss these comments further. I can be reached at jlozier@nhhc.org or at 615-226-2292.

Respectfully submitted,



John Lozier, MSSW
Executive Director

Endorsing Organizations:

- Colorado Coalition for the Homeless
- Community Solutions
- Corporation for Supportive Housing
- Covenant House
- Give US Your Poor: The Campaign to End Homelessness
- Horizons for Homeless Children
- National Alliance to End Homelessness
- National Association for the Education of Homeless Children and Youth
- National Center on Family Homelessness
- National Coalition for the Homeless
- National Law Center on Homelessness and Poverty
- Western Regional Advocacy Project